SENATE BILL 720
By Watson

HOUSE BILL 315

By DeBerry J

AN ACT to amend Tennessee Code Annotated, Title 56, relative to credentialing and contracting of healthcare providers by health insurance entities.

WHEREAS, health care providers who are newly licensed, who move into a new community or who change practices must complete and submit a credentialing application to be reviewed and approved by a health insurance entity followed by approval of a contract between the provider and health insurance entity in order for the provider to be considered as an in-network provider; and

WHEREAS, any undue delays in processing the paperwork could limit patients' access to health care services because the provider is not considered an in-network provider; and

WHEREAS, health insurance entities ultimately approve an overwhelming percentage of those providers who desire to participate in the entities' provider networks; now, therefore,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new, appropriately designated section:

SECTION 56-7-___

(a) A health insurance entity, as defined in § 56-7-109, which is:

(1) A participating organization of the Council on Affordable Quality Healthcare (CAQH) or its successor shall reimburse a health care provider as an in-network provider for health care services after receipt of a completed CAQH credentialing application if the health insurance entity has not completed processing the application and either signed or refused to sign a provider contract and notified the health care provider of the provider's status within forty-five (45) calendar days after receipt of the application.

(2) A health insurance entity, as defined in § 56-7-109, which is not a participating organization of the Council on Affordable Quality Healthcare or its successor shall reimburse a health care provider as an in-network provider for health care services after receipt from the health care provider of a completed CAQH credentialing application if the health insurance entity has not completed processing the application and either signed or refused to sign a provider contract and notified the health care provider of the provider's status within forty-five (45) calendar days after receipt of the application.

(3) In those cases where the health insurance entity has not completed the process as set forth in either (1) or (2) above within forty-five (45) calendar days after receipt of the completed credentialing application, the entity shall reimburse the provider for services delivered to network members beginning on the forty-sixth (46th) day and continue to reimburse the health care provider as an in-network provider until such time as the carrier has concluded the process and notified the provider that the provider will not be included in the entity's provider network. A provider who is ultimately included in the entity's provider network shall continue to be reimbursed as an in-network provider until the contract is modified or terminated at a future date.

(b) A health insurance entity, as defined in § 56-7-109, that is required by CAQH to issue a user ID and password to a health care provider who wants to complete and submit a CAQH credentialing application shall issue the necessary user ID and password within five (5) business days of the receipt of the request from the Council on Affordable Quality Healthcare.

(c) Unless required by a national accrediting body, a health insurance entity shall accept and begin processing a completed credentialing application, whether a CAQH or

the health insurance entity's application, as early as ninety (90) calendar days before the anticipated employment start date of the health care provider.

(d) Unless required by a national health insurance entity accrediting body, a health insurance entity shall not mandate, in order to process a credentialing application, whether a CAQH or the health insurance entity's application, that a health care provider have an active malpractice insurance policy and bear the unnecessary costs of the premiums before the provider's employment start date.

(e) No health insurance entity shall reflect in either written material sent to its members or on a website available to its members that a health care provider is an in-network provider or that the provider's credentialing application is pending approval until such time as a contract is signed by both the provider and the health insurance entity.

(f) The commissioner has the authority, if deemed necessary to promulgate public necessity rules in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

(g) The commissioner has the authority to determine a violation of Title 56, Chapter 7, Part 10 and may issue a cease and desist order and assess civil penalties pursuant to Tennessee Code Annotated, Section 56-8-109.

(h) The provisions of this act shall not be applicable to the state group insurance program, local government health insurance plans or to the state's medical assistance program established pursuant to Title XIX of the Social Security Act.

SECTION 2 Tennessee Code Annotated, Section 56-8-104, is amended by adding the following:

(15) *CREDENTIALING APPLICATIONS*. Any violation of the laws dealing with credentialing applications, contracting and reimbursement as set forth in Title 56, Chapter 7, Part 10.

SECTION 3. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to the end the provisions of this act are declared to be severable.

SECTION 4. This act shall take effect on July 1, 2007, the public welfare requiring it.